BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
PETER PHONG LY, M.D.	)	**Case No. 800-2015-017493**
Physician's and Surgeon's Certificate No. A65780	)	
Respondent	)	

ORDER CORRECTING NUNC PRO TUNC
CLERICAL ERROR IN "LICENSE NUMBER" PORTION ON DISCIPLINARY ORDER PAGE OF DECISION

On its own motion, the Medical Board of California (hereafter "board") finds that there is a clerical error in the "license number" portion on Disciplinary Order page of the Decision in the above-entitled matter and that such clerical error should be corrected so that the license number will conform to the Board's issued license.

IT IS HEREBY ORDERED that the license number contained on the Disciplinary Order page of the Decision in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as "A65780".

IT IS SO ORDERED: June 6, 2019

MEDICAL BOARD OF CALIFORNIA

Ronald Lewis, M.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
PETER PHONG LY, M.D.	)	Case No. 800-2015-017493
Physician's and Surgeon's Certificate No. A65780	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 21, 2019.

IT IS SO ORDERED: May 23, 2019.

MEDICAL BOARD OF CALIFORNIA

Ronald Lewis, M.D., Chair
Panel A

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Attorney General of California
JUDITH T. ALVARADO
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Peter Phong Ly, M.D.** **Physician's and Surgeon's Certificate No. A65780,** **Respondent.**	**Case No. 800-2015-017493** **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Tan N. Tran, Deputy Attorney General.

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2. Respondent Peter Phong Ly, M.D. ("Respondent") is represented in this proceeding by attorney Carlo A. Spiga, Esq., whose address is: 655 North Central Avenue, Suite, 1700, Glendale, CA 91203.

3. On or about June 26, 1998, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 65780 to Peter Phong Ly, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-017493 and will expire on January 31, 2020 unless renewed.

JURISDICTION

4. Accusation No. 800-2015-017493 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on or about June 11, 2018. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2015-017493 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-017493. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2015-017493, and that he has thereby subjected her Physician's and Surgeon's Certificate No. A 65780 to disciplinary action.

10. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 72189 issued to Peter Phong Ly, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and

successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of

this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring

responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

5. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation

Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

STANDARD CONDITIONS

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the

Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject

to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Carlo A. Spiga, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 4/4/15

Peter Phong Ly, M.D.
Respondent

I have read and fully discussed with Respondent the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 4/4/15

Carlo A. Spiga, Esq.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 4/4/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

TAN N. TRAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-017493

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Peter Phong Ly, M.D.** **8016 Second Street** **Downey, CA 90241** **Physician's and Surgeon's Certificate No. A 65780,** Respondent.	Case No. 800-2015-017493 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 26, 1998, the Medical Board issued Physician's and Surgeon's Certificate Number A 65780 to Peter Phong Ly, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code provides:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 2266 of the Code provides:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 725 of the Code, in pertinent part, provides:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

". . . ."

8. Health and Safety Code section 11152 provides:

"No person shall write, issue, fill, compound, or dispense a prescription that does not

conform to this division."

9. Health and Safety Code section 11153, in pertinent part, provides

"(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

". . . ."

10. Health and Safety Code section 11190, in pertinent part, provides:

"(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

"(1) The name and address of the patient.

"(2) The date.

"(3) The character, including the name and strength, and quantity of controlled substances involved.

"(b) The prescriber's record shall show the pathology and purpose for which the controlled substance was administered or prescribed.

"(c) (1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to Section 4170 of the

Business and Professions Code, the prescriber shall record and maintain the following information:

"(A) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the patient.

"(B) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

"(C) NDC (National Drug Code) number of the controlled substance dispensed.

"(D) Quantity of the controlled substance dispensed.

"(E) ICD-9 (diagnosis code), if available.

"(F) Number of refills ordered.

"(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

"(H) Date of origin of the prescription.

"(2) (A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation.

"(B) The reporting requirement in this section shall not apply to the direct administration of a controlled substance to the body of an ultimate user.

"(d) This section shall become operative on January 1, 2005.

"(e) The reporting requirement in this section for Schedule IV controlled substances shall not apply to any of the following:

"(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

"(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.

"(f) Notwithstanding paragraph (2) of subdivision (c), the reporting requirement of the information required by this section for a Schedule II or Schedule III controlled substance, in a format set by the Department of Justice pursuant to regulation, shall be on a monthly basis for all of the following:

"(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

"(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005."

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

11. The following medications are controlled substances and dangerous drugs within the meaning of the Health and Safety Code and Business and Professions Code:

A. MS Contin—also known as morphine, a Scheduled II controlled substance, used to treat moderate to severe pain.[1]

B. Tramadol—a similar to morphine, a Scheduled II controlled substance used to treat moderate to severe pain.[2]

C. Gabapentin—a prescriptive drug used to treat seizure disorders and nerve damage from shingles

D. Carisoprodol—also known as Soma, a prescriptive drug used to treat pain and relax muscles

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he committed gross negligence during his care, treatment, and management three patients, as follows:

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[1] MS Contin exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death. Tramadol (Ultram, Ultram ER, Conzip) is a drug used to treat moderate to moderately severe pain. It works similar to morphine

[2] Tramadol (also known as Ultran, Ultram ER, Conzip) is used to treat moderate to moderately sever pain.

Patient No. 1.

A. Patient No. 1 presented to Respondent when he was 20 years old with a with a complaint of testicular pain several years after an inguinal hernia repair. The patient also complained of low back and knee pain. His first clinic visit was October 16, 2014; thereafter, he was seen approximately every month until August 2016. Treatment consisted of low back injections, opioids such as MS Contin and Tramadol as well as Gabapentin, and Carisoprodol (Soma). Patient No. 1 signed an opioid agreement on October 16, 2014.

B. Respondent failed to comply with the applicable standard of care for prescribing controlled substances and other dangerous drugs. Respondent failed to take a proper medical history and perform an adequate physical examination, including an assessment of the pain, physical and psychological factors; a substance abuse history; history of prior pain management; assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of controlled substances.

C. Further, Respondent's medical records for Patient No. 1 do not show that Respondent met these requirements. Respondent's initial consultation is only a one-page handwritten note. No details about the patient's past medical history or current complaints are provided. Current and past medications are not listed. Vital signs are not provided and the only recorded findings on the physical exam are that the patient's gait appears painful, he has tenderness somewhere in his low back and that he has pain with rotation and flexion of his low back. The clinical diagnoses at this initial visit are not supported and clinical reasoning for use of controlled substances are not documented.

D. Documentation of follow-up visits are as limited as the notes in the first visit and do not provide enough detail, assessment, or medical reasoning to justify the use of controlled substances.

E. The manner in which Respondent prescribed controlled substances and other dangerous drugs to Patient No. 1 was an extreme departure from the standard of care.

F. Physicians are required to maintain treatment plans for their patients. The treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician and the surgeon should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the patient is complex or is associated with physical and psychosocial impairment.

G. Respondent's records for Patient No. 1 are very difficult to read and make it almost impossible to follow the treatment of this patient. The recorded information that was not illegible was minimal. Documentation of medications prescribed by Respondent were frequently only copies of his hand written prescriptions and did not explain why medications were started, continued, or stopped.

H. The manner of Respondent prescribing for Patient No. 1 is an extreme departure from the standard of care.

I. The physician should give special attention to those pain patients who are at risk for misusing the medications, including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation, as well as consultation with an addiction medicine specialist. It may also entail the use of an agreement between the provider and the patient that specifies the rules for medication use and consequences for misuse.

J. Respondent did not document the risk of misuse or abuse of controlled substances with Patient No. 1. However, due to the patient's age (20-year old), and high daily dose of opioids, he was at increased risk for abuse. When patients have increased risk for developing misuse, abuse, or addiction, more objective monitoring is required. This includes showing functional improvement; random urine drug screening and reviewing the CURES database.

K. A review of the clinical records did not show this. During an interview with

representatives of the Medical Board of California, Respondent advised that the patient was urine drug tested at least once a year but documentation that urine drug screens were completed was not in the record.

L. This is simple departure from the standard of care.

M. The physician and surgeon should keep accurate and complete medical records according to items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, and rationale for changes in the treatment plan or medications, agreements with the patient and periodic review of treatment plan. Again, the medical records were very difficult to read and lacked vital information. In addition, the records lacked documentation of the controlled substances being taken by Patient No. 1 as well as any interventional pain procedures instituted by Respondent and others. The standard of care requires that these types of procedures are recorded in the medical record. The location of the injection, medication used and surgical technique are important to determine efficacy and need to be readily available should complications occur. The record did not have complete documentation of the multiple invasive procedures that Respondent performed on Patient No. 1.

N. This was an extreme departure from the standard of care.

Patient No. 2

O. Respondent first saw Patient No. 2, then 26 years old, on October 10 2013.

P. Respondent saw Patient No. 2 approximately every month until July 2016. Respondent advised representatives of the Medical Board of California that Patient No. 2 had leukemia at about age 5, underwent chemotherapy and was being treated for rheumatoid arthritis by her primary care provider.[3]

[3] The patient also may have had fibromyalgia but that information was not in Respondent's records

Q. Respondent's medical records for Patient No. 2 do not document the cause of her pain. She was treated with injections, opioids (MS Contin 60 mg bid, hydromorphone 4 mg q 4 hours) and Carisoprodal. She also received steroid injections at nearly every visit An opioid agreement was not contained in the patient's records. The patient's chart did contain one urine drug screen dated December 3, 2013.

R. Beginning with the initial visit on October 10, 2013, Respondent's medical records contained a three-page questionnaire, which the patient had completed along with one-page clinic note. This initial consultation has three abbreviations in the history of present illness and only state where the patient's pain is located. It does not provide other details about the pain or the history of the pain. No past medical history was recorded in the clinic note nor were any vital signs recorded. The current medications recorded in the questionnaire are not the same as what is recorded in the clinic note. The physical examination is not complete and there were only three findings; tenderness to palpation in the neck and back and a third finding which is not legible. The clinical diagnoses at this initial visit are not supported and clinical reasoning for use of controlled substances is not documented. Documentation of follow-up visits are just as limited as the first visit and do not provide enough detail, assessment, or medical reasoning to justify the use of controlled substances.

S. Again, the treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function. It should also indicate whether any further diagnostic evaluations or other treatments are planned. The physician and the surgeon should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the patient is complex or is associated with physical and psychosocial impairment. As with the other patients, Respondent's clinic records are very difficult to read and made it almost impossible to follow treatment of this patient. What was legible was limited and provided minimal information about the patient's condition. The subjective section of the clinic notes provided little more than the

patient's chief complaint. Vital signs, review of systems, and medications not prescribed by Respondent were not recorded at follow-up visits. Documentation of medications prescribed by Respondent were frequently only copies of his handwritten prescriptions and did not explain why medications were started, continued, or stopped.

T. The physician or surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian. Here, there was no documentation of these types of discussions was not found and there was no signed opioid agreement in the record.

U. Respondent's failure to discuss the risks and benefits of the use of controlled substances constitutes a simple departure from the standard of care.

V. A physician and surgeon should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain management specialist. In addition, the physician should give special attention to those pain patients who are at risk for misusing the medications, including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation, as well as consultation with an addiction medicine specialist. It may also entail the use of an agreement between the provider and the patient that specifies the rules for medication use and consequences for misuse.

W. Respondent did not document the risk of misuse or abuse when prescribing controlled substances with this patient. However, due to the patient's age, concurrent use of a benzodiazepine, and high total daily dose of opioids, the patient was at an increased risk for abuse. When patients have increased risk for developing misuse, abuse or addiction, more objective monitoring is required. This includes demonstrating

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functional improvement; random urine drug screening, and reviewing the CURES database. Review of the clinical records did not indicate that any of these actions were performed.[4]

X. This is a simple departure from the standard of care.

Y. The physician and surgeon should keep accurate and complete medical records according to items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, and rationale for changes in the treatment plan or medications, agreements with the patient, and periodic review of treatment plan.

Z. Respondent's medical records for Patient No. 2 were very difficult to read and lacked vital information. Along with the lack of documentation surrounding controlled substances, Respondent did not document interventional pain procedures. It is the standard of care that these types of procedures are recorded in the medical record. The location of the injection, medication used and surgical technique are important to determine efficacy and need to be readily available should complications occur. The record did not have any complete documentation of the multiple invasive procedures that Respondent performed on this patient.

AA. This is an extreme departure from the standard of care.

Patient No. 3

BB. Respondent initially saw Patient No. 3 on December 28, 2012, when her primary care provider stopped providing opioids for her pain. She complained of long-standing low back pain and newer onset hip pain. She was treated with injections and opioids (MS Contin 15 mg bid and Percocet 10/325 6 times per day). An opioid agreement was signed on December 28, 2012. Review of the patient's Patient Activity Report shows that Respondent first prescribed hydrocodone 5/500 #10 on August 3, 2011.

[4] During an interview with representatives of the Medical Board of California, Respondent stated that the patient was urine drug tested at least once a year but there was only one UDT in the record during the nearly three years of treatment. Respondent further stated that he did not review the CURES database and expected retail pharmacists to do this for him.

CC. Yet again, Respondent failed to take a medical history or perform an adequate physical examination for this patient. A medical history and physical examination must be conducted to comply with the standard of care. This includes an assessment of the pain, physical and psychological factors; a substance abuse history; history of prior pain management; an assessment of underlying, coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.

DD. Respondent's medical records for Patient No. 3 do not show that Respondent met the necessary requirements. Starting with his initial visit on December 28, 2012, one record contained a three page questionnaire, which the patient completed, and a one-page clinic note. This initial consultation contains two abbreviations in the history of present illness, which simply say where the patient's pain is located and provides no other details. No past medical history is recorded in the clinic notes nor were vital signs recorded. The current medications are not recorded completely. The physical exam is only one line long and not legible. The clinical diagnoses provided at this initial visit are not supported and clinical reasoning for the use of controlled substances are not documented. Documentation of follow up visits are just as limited as the first visit and do not provide enough detail, assessment, or medical reasoning to justify the use of controlled substances.

EE. Respondent's failure to document his care, treatment and management of Patient No. 3 constitutes an extreme departure from the standard of care.

FF. Respondent, again, had no treatment plan or objectives for this patient. The treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician and surgeon should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the patient is complex or is associated with physical and psychosocial impairment.

GG. What was legible was limited and provided minimal information about the patient's condition. The subjective section of the clinic notes provided little more than the patient's chief complaint. Vital signs, review of systems, and medications not prescribed by Respondent were not recorded at follow-up visits. Documentation of medications prescribed by Respondent were frequently only copies of his handwritten prescriptions and did not explain why medications were started, continued, or stopped.

HH. This is an extreme departure from the standard of care.

II. The physician and surgeon should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain management specialist. In addition, the physician should give special attention to those pain patients who are at risk for misusing the medications, including those whose living arrangements pose a risk for medication misuse. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation, and consultation with an addiction medicine specialist, and may entail use of an agreement between the provider and the patient that specifies the rules for medication use and consequences for misuse.

JJ. Respondent did not document the risk of misuse or abuse when prescribing controlled substances with this patient. But due to the patient's continued use of a benzodiazepine and high total daily dose of opioids (> 120 mg of morphine equivalents per day), she was clearly at increased risk for abuse. When patients have increased risk for developing misuse, abuse, or addiction, more objective monitoring is required. This includes documenting functional improvement, random urine drug screening and reviewing the CURES database. Review of the clinical records did not reflect that these steps were taken. Respondent states that the patient was urine drug tested at least once a year but no urine drug screens were documented in the record. Respondent admitted to representatives of the Medical Board

that he did not review the CURES database and expected retail pharmacists to do this for him.

KK. Respondent's failure to document that he discussed the risk of abuse with Patient No. 3 and his failure to record the functional improvement or lack of improvement constitute a simple departure from the standard of care.

LL. A physician and surgeon should keep accurate and complete medical records, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, and rationale for changes in the treatment plan or medications, agreements with the patient, and periodic review of treatment plan.

MM. Respondent failed to keep accurate and complete medical records. Like his records for Patient No. 1 and Patient No. 2, the medical records prepared by Respondent for Patient No. 3 were very difficult to read and lacked vital information. Along with the lack of documentation surrounding controlled substances, the fact that Respondent did not document interventional pain procedures in his clinic is very concerning. It is the standard of care that these types of procedures are recorded in the medical record. The location of the injection, medication used and surgical technique are important to determine efficacy and need to be readily available should complications occur. The record did not have complete documentation of the multiple invasive procedures that Respondent performed on this patient.

NN. Respondent's failure to document his care, treatment and management of Patient No. 3 constitutes an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

13. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts during the care, treatment, and management of Patients Nos. 1, 2, and 3, as described in paragraph 12, above, as follows:

A. Complainant refers to and, by the reference, incorporates herein paragraph 12, above, as though fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing)

14. Respondent is subject to disciplinary action under Business and Professions Code section 725 in that he engaged in repeated acts of clearly excessive prescribing for Patients Nos. 1, 2 and 3, as described in paragraph 12, above, as follows:

A. Complainant refers to and, by the reference, incorporates herein paragraph 6, above, as though fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

15 Respondent is subject to disciplinary action under Business and Professions Code section 2266 in that he failed to prepare and maintain adequate and accurate medical records for Patients Nos. 1, 2 and 3, as described in paragraph 12, above, as follows:

A. Complainant refers to and, by the reference, incorporates herein paragraph 12 above, as though fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

16. Respondent is subject to disciplinary action under Business and Professions Code section 2234 in that he committed unprofessional conduct, generally, during his care, treatment and management of Patients Nos. 1, 2 and 3, as described in paragraph 12, above, as follows:

A. Complainant refers to and, by the reference, incorporates herein paragraph 12, above, as though fully set forth.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 65780, issued to Peter Phong Ly, M.D.;

2. Revoking, suspending or denying approval of Peter Phong Ly, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Peter Phong Ly, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: June 11, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant